

Do Your Part to Prevent COVID-19 Vaccine Administration Errors A Primer for Health Care Workers

Andrew Kroger, MD, MPH
Hosted by the WA Department of Health
April 29, 2021



Moderator



Phil Wiltzius, MS, CHES

Health Educator
Washington Department of Health
Center for Public Affairs

Before We Start...

- All participants will be muted for the presentation.
- You may ask questions using the Q&A box, and questions will be answered at the end of the presentation.
- Continuing education is available for nurses, medical assistants, and pharmacists attending the webinar or watching the recording. If you're watching in a group setting and wish to claim CE credit, please make sure you register for the webinar as an individual and complete the evaluation separately.
- You can find a copy of the slides and more information on our webinar page here:
www.doh.wa.gov/YouandYourFamily/Immunization/ImmunizationNews/ImmunizationTraining/PreventCOVID19VaccineAdministrationErrorsWebinar

Presenter



Andrew Kroger, MD, MPH, Medical Officer
Communication and Education Branch, Immunization Services Division
CDC National Center for Immunization and Respiratory Diseases

Continuing Education Disclosure

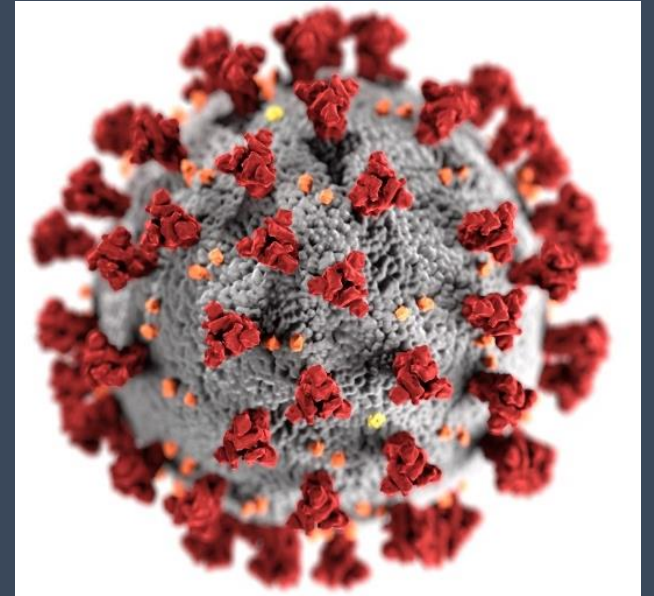
- The planners and speakers of this activity have no relevant financial relationships with any commercial interests pertaining to this activity.
- Information about obtaining CEs will be available at the end of this webinar.

Continuing Education

- This continuing nursing education activity was approved by the Montana Nurses Association, an accredited approver with distinction by the American Nurses Credentialing Center's Commission on Accreditation. Upon successful completion of this activity, 1.0 contact hours will be awarded.
- This program has been granted prior approval by the American Association of Medical assistants (AAMA) for 1.0 administrative continuing education unit.
- This training was approved by the Washington State Pharmacy Quality Assurance Commission (PQAC) for pharmacist education. Upon successful completion of this activity, 1.0 credit hour of continuing education will be awarded.

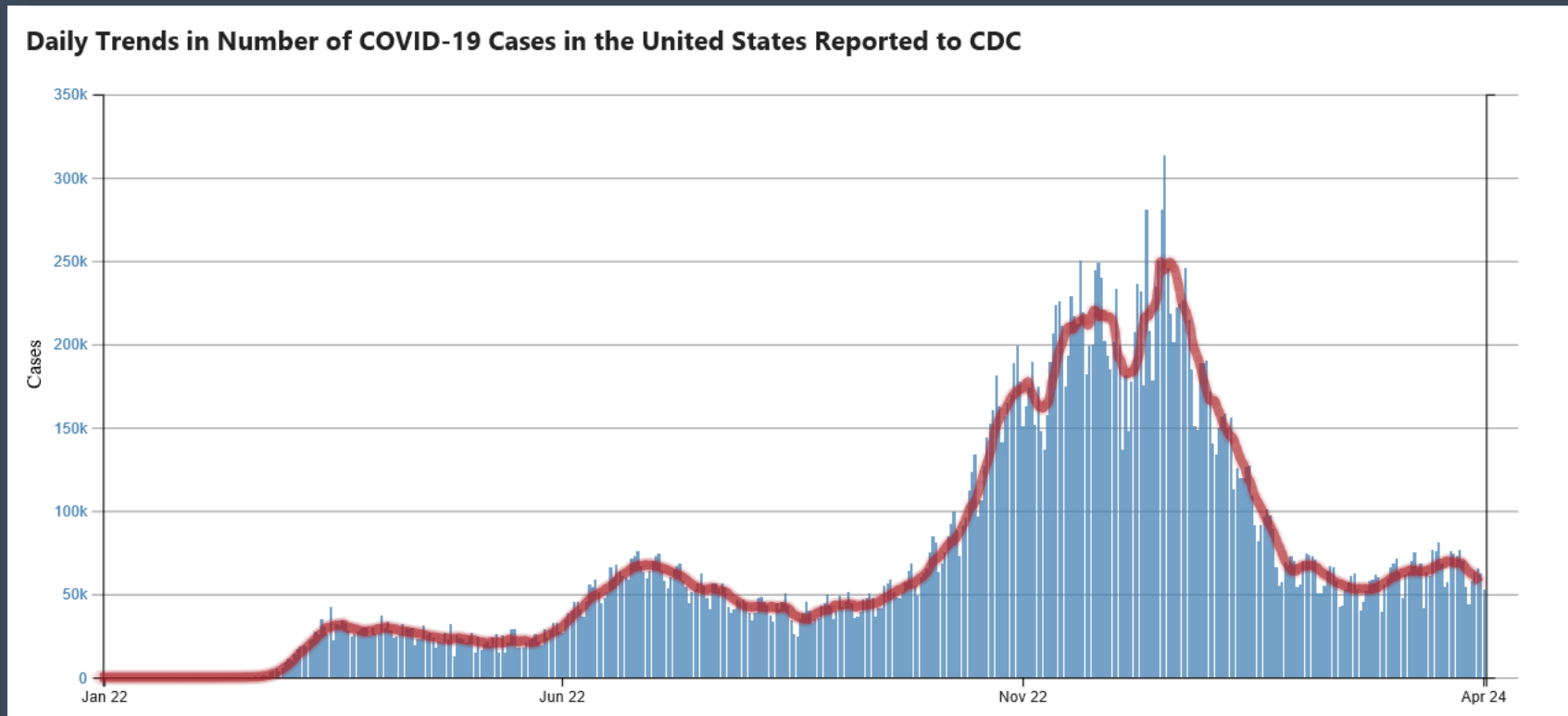
COVID-19: Emergence

- Identified in Wuhan, China in December 2019
- Caused by the virus SARS-CoV-2
- Early on, many patients were reported to have a link to a large seafood and live animal market.
- Later patients did not have exposure to animal markets.
 - Indicated person-to-person spread
- Travel-related exportation of cases reported
 - First U.S. case: January 20, 2020
https://www.cdc.gov/mmwr/volumes/69/wr/mm6924e2.htm?s_cid=mm6924e2_w
- CDC is reporting confirmed COVID-19 cases in the U.S. online.
at www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html



COVID-19: Epidemiology

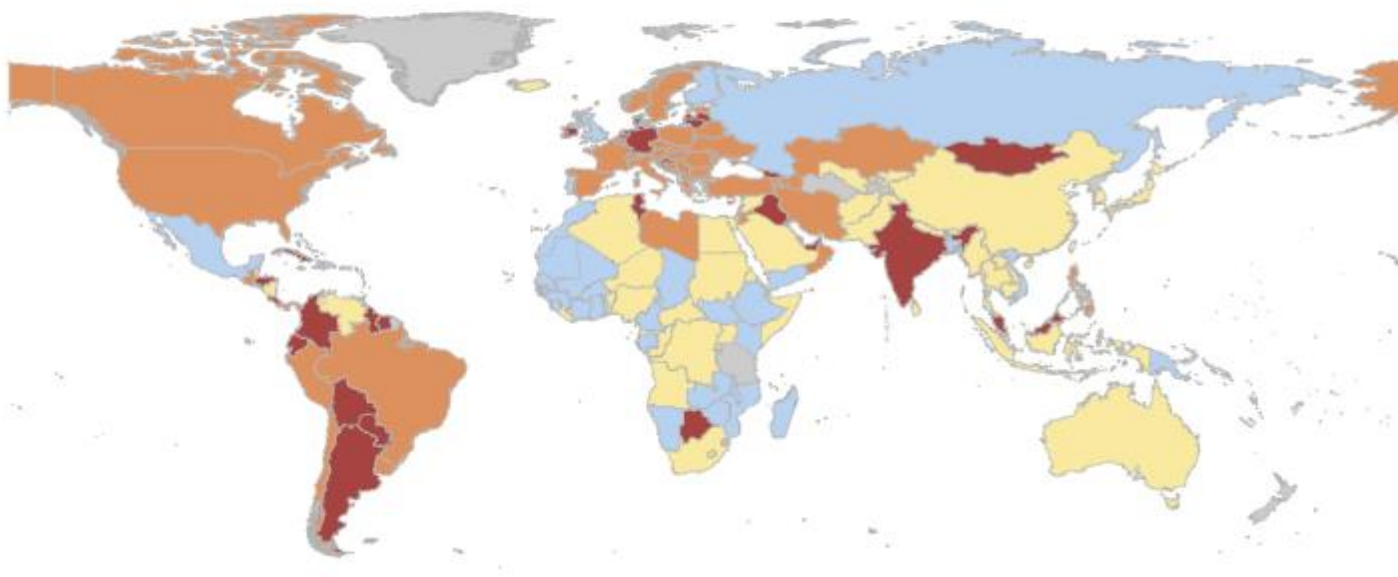
- https://covid.cdc.gov/covid-data-tracker/#trends_dailytrendscases (April 26, 2021)



COVID-19: Epidemiology

- <https://covid.cdc.gov/covid-data-tracker/#global-counts-rates> (April 26, 2021)

Epidemic Curve Trajectory Classification



Epidemic curve trajectory categories*

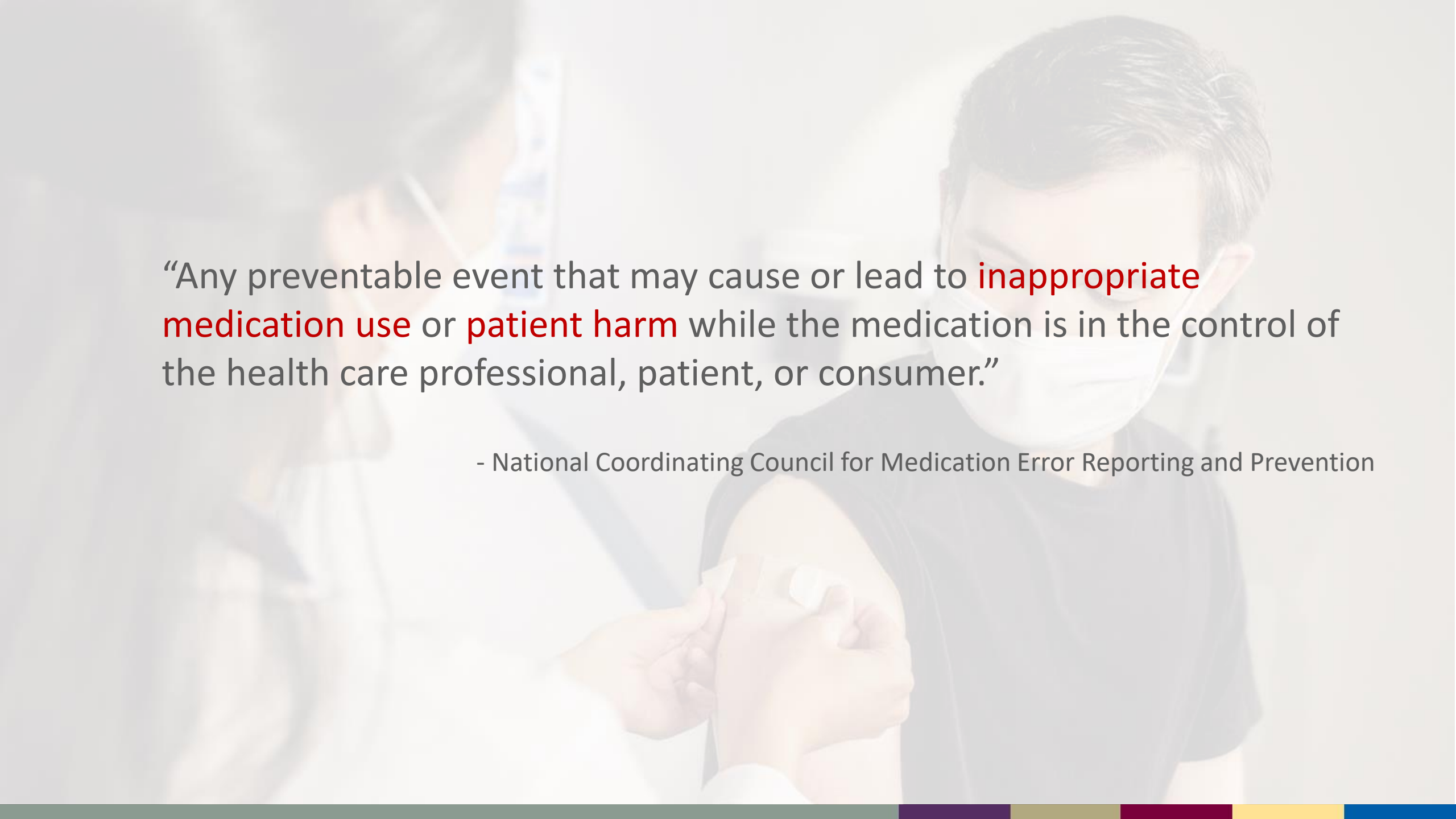
- <10 Cases in past 7 days
- Low/Moderate Incidence, Decreasing
- Low/Moderate Incidence, Increasing
- Substantial/High Incidence, Decreasing
- Substantial/High Incidence, Increasing



- **Recognize** common vaccine administration errors
- **Prevent** errors from occurring
- **Build** public trust in all vaccines



What Is a Vaccine Administration Error?



“Any preventable event that may cause or lead to **inappropriate medication use** or **patient harm** while the medication is in the control of the health care professional, patient, or consumer.”

- National Coordinating Council for Medication Error Reporting and Prevention

Causes of Vaccine Administration Errors



Insufficient staff training



Lack of standardized protocols



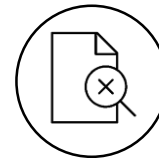
Patient misidentification



Product misidentification



Changes in recommendations



Using nonstandard or
error-prone abbreviations

Common Vaccine Administration Errors

Scheduling Errors

Wrong Patient

Wrong Vaccine, Route, Site, or Dosage

Incorrect Vaccine Preparation

**Improper Storage and Handling of Vaccine
and Diluent**

Documentation Errors

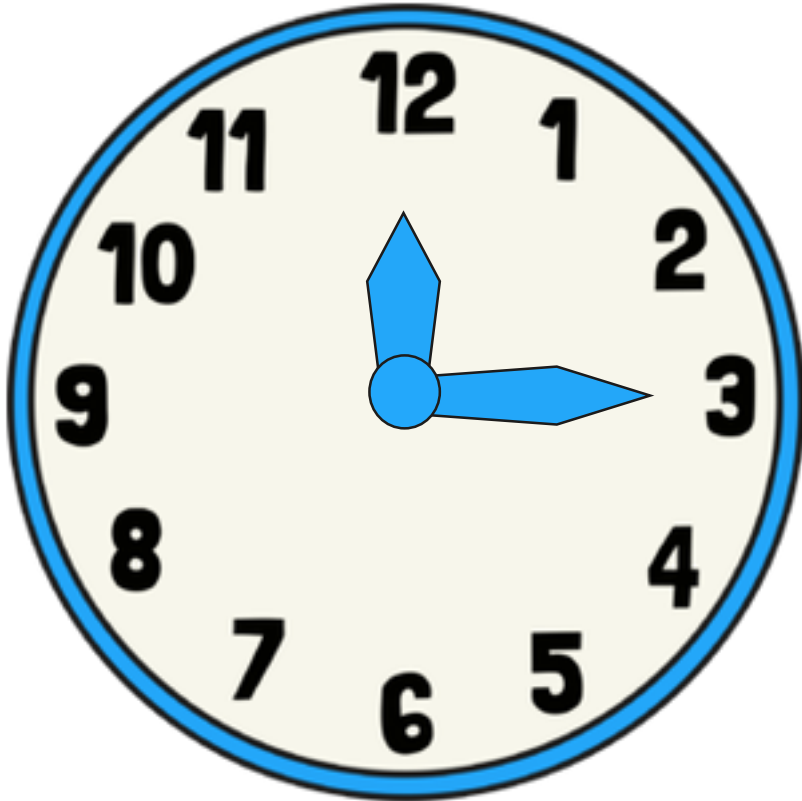
Common Vaccine Administration Errors

Scheduling Errors

Wrong



What Is a Scheduling Error?



Any dose administered **too early**

- Before the minimum time interval between doses
- Before the minimum age

What Is a Scheduling Error?



- 21 Days between Doses



- 28 Days between Doses

What Is a Scheduling Error?



- 16 years old



- 18 years old

Preventing Scheduling Errors

- Standing orders
- Screening checklist
- Proactively scheduling the second appointment
- Immunization information systems
- Personal/provider records

Scheduling Second Appointment



- **Do NOT** use grace period to schedule second dose

Scheduling Second Appointment



- 21 days between doses
- 28 days between doses
- No maximum interval, but recommend within 6 weeks

Scheduling Second Appointment



- **21** days between doses
- **28** days between doses
- **DO NOT** restart the series if these intervals are missed

Common Vaccine Administration Errors

Scheduling Errors

Wrong Patient

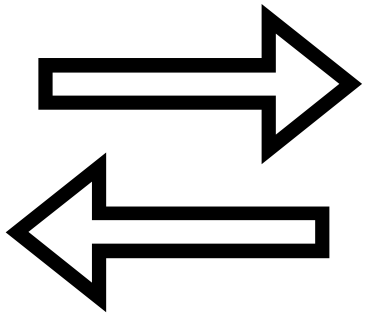
Wrong Vaccine, Route, Site, or Dosage

Incorrect Vaccine Preparation

Improper Storage and Handling of Vaccine
and Diluent

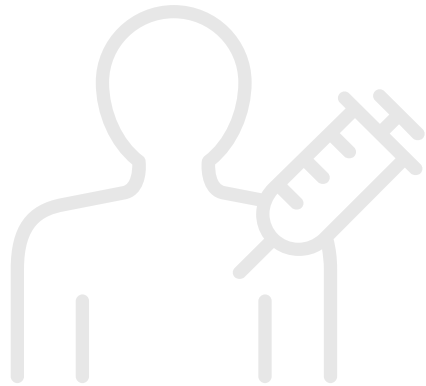
Documentation Errors

Common Errors



Wrong Vaccine

Second dose swapped with another product; receiving antibodies instead of vaccine



Wrong Route

Subcutaneous instead of intramuscular



Wrong Site

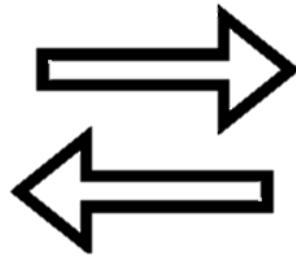
Missed the deltoid muscle; injected into bursa or nerves



Wrong Dosage

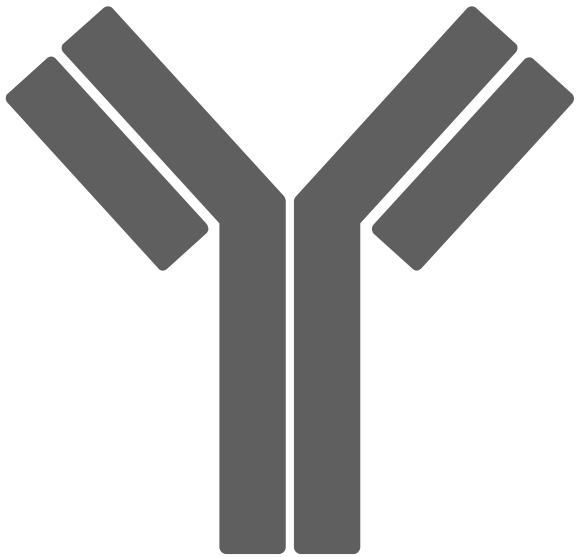
Insufficient/excess Amount

Wrong Vaccine

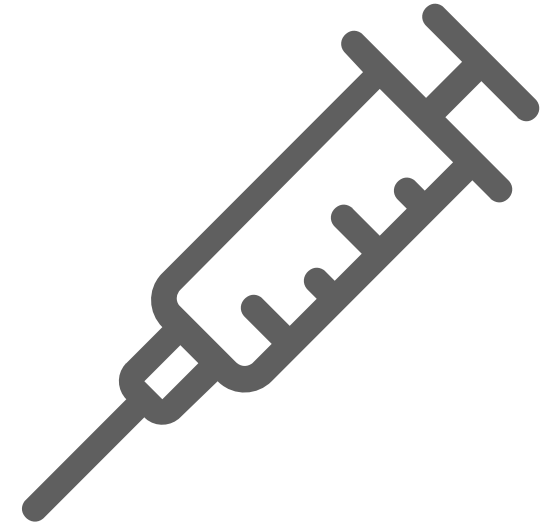


moderna®

Wrong Vaccine

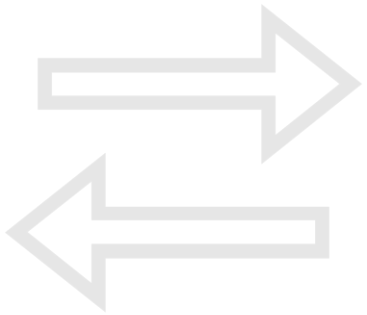


**COVID-19
Antibodies**



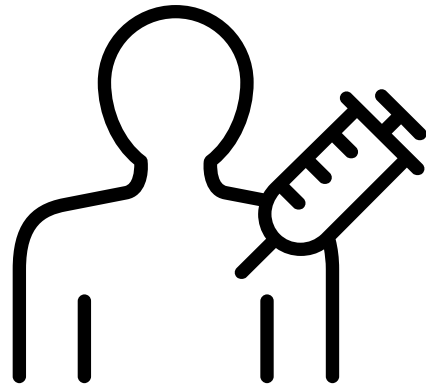
**COVID-19
Vaccine**

Common Errors



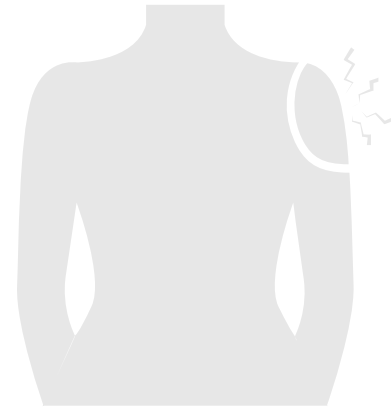
Wrong Vaccine

Second dose swapped with another product; receiving antibodies instead of vaccine



Wrong Route

Subcutaneous
instead of
intramuscular



Wrong Site

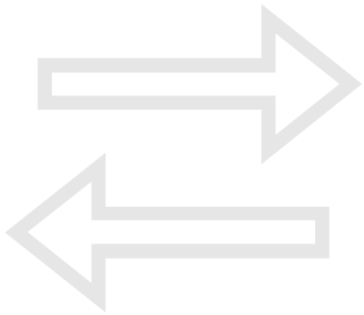
Missed the deltoid muscle;
injected into bursa or nerves



Wrong Dosage

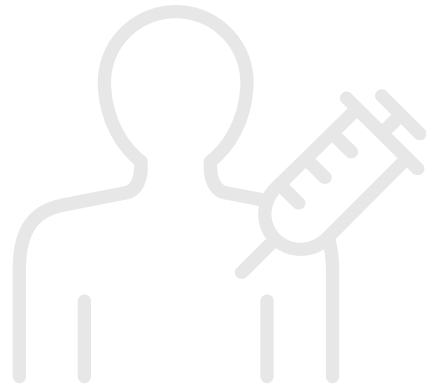
Insufficient/excess
Amount

Common Errors



Wrong Vaccine

Second dose swapped with another product; receiving antibodies instead of vaccine



Wrong Route

Subcutaneous instead of intramuscular



Wrong Site

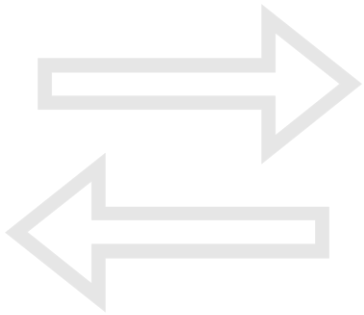
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Wrong Dosage

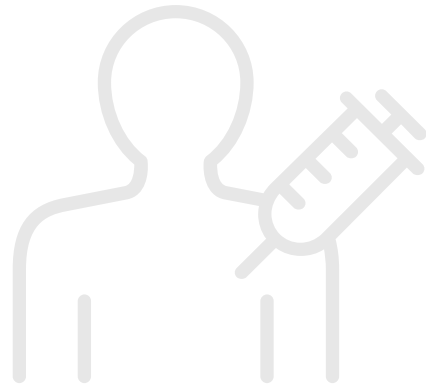
Insufficient/excess Amount

Common Errors



Wrong Vaccine

Second dose swapped with another product; receiving antibodies instead of vaccine



Wrong Route

Subcutaneous instead of intramuscular



Wrong Site

Missed the deltoid muscle; injected into bursa or nerves



Wrong Dosage

Insufficient/excess Amount

Preventing Wrong Vaccine, Site, Route, Dosage

- Store different products in separate bins
- Use color coded identification labels
- Establish “do not disturb areas”
- Triple check the vaccine vial label
- Standing orders

MORE DIFFICULT IN A MASS CLINIC SETTING

- Prepare vaccine for one patient at a time
- Do not administer vaccine prepared by someone else

Common Vaccine Administration Errors

Scheduling Errors

Wrong Patient

Wrong Vaccine, Route, Site, or Dosage

**Improper Storage and Handling of Vaccine
and Diluent**

Documentation Errors

Preventing Improper Storage and Handling of Vaccine and Diluent



Remove vaccines exposed to improper temperatures



Train staff on proper storage and handling

Preventing Improper Storage and Handling of Vaccine and Diluent

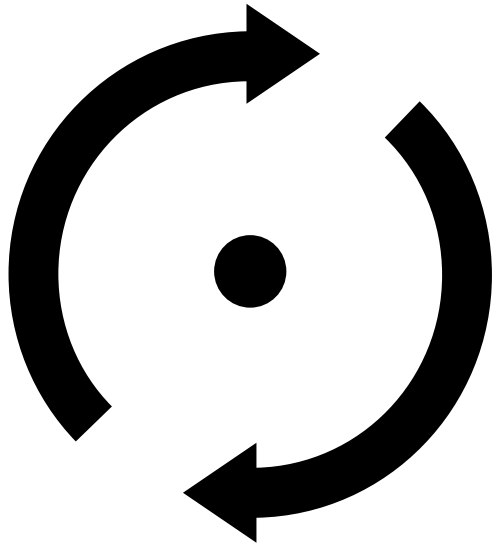


Remove vaccines exposed to
improper temperatures



**Train staff on proper
storage and handling**

Preventing Improper Storage and Handling of Vaccine and Diluent

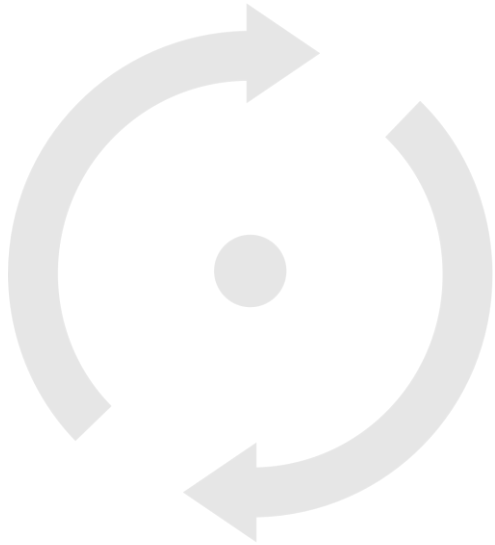


**Rotate vaccines in
storage unit**



**Remove expired
vaccines and diluents**

Preventing Improper Storage and Handling of Vaccine and Diluent



Rotate vaccines in
storage unit



**Remove expired
vaccines and diluents**

Common Vaccine Administration Errors

Scheduling Errors

Wrong Patient

Wrong Vaccine, Route, Site, or Dosage

Incorrect Vaccine Preparation

Improper Storage and Handling of Vaccine
and Diluent

Documentation Errors

Preventing Wrong Patient



**Verify patient's
identity**



**Prepare vaccines for
one patient at a time**

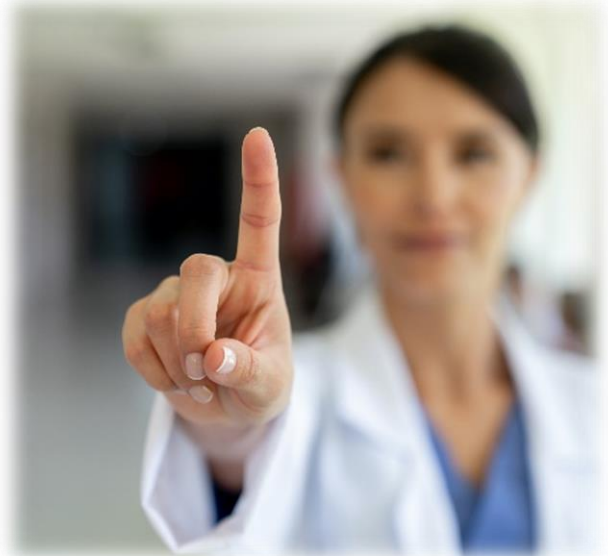


Train staff

Preventing Wrong Patient



Verify patient's
identity



Prepare vaccines for
one patient at a time



Train staff

Preventing Wrong Patient



Verify patient's
identity



Prepare vaccines for
one patient at a time



Train staff

Common Vaccine Administration Errors

Scheduling Errors

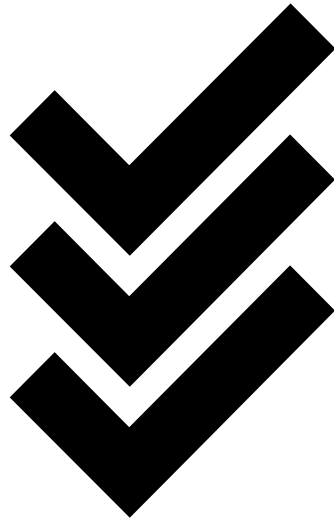
Wrong Vaccine, Route, Site, or Dosage

Improper Storage and Handling of Vaccine
and Diluent

Incorrect Vaccine Preparation

Documentation Errors

Preventing Incorrect Vaccine Preparation



Triple-check instructions and labels



Verify correct needle size

Preventing Incorrect Vaccine Preparation

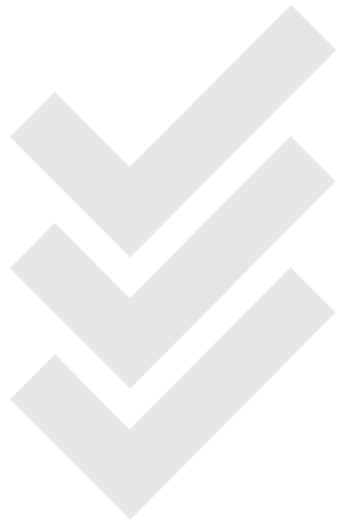


Triple-check instructions and labels

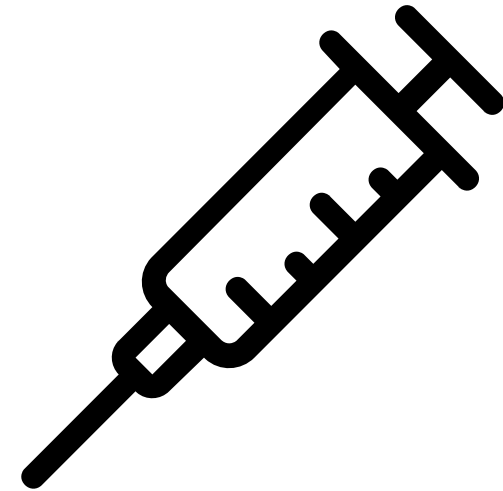


Verify correct needle size

Preventing Incorrect Vaccine Preparation



Triple-check instructions and labels



Verify correct needle size

Common Vaccine Administration Errors

Scheduling Errors

Wrong Patient

Wrong Vaccine, Route, Site, or Dosage

Incorrect Vaccine Preparation

Improper Storage and Handling of Vaccine
and Diluent

Documentation Errors

Documentation Errors



**Incorrect dose
numbers**

**Incorrect lot
numbers**

Documentation Errors



**Incorrect dose
numbers**

**Incorrect lot
numbers**

Preventing Documentation Errors



**Report to immunization
information system
within 72 hours**

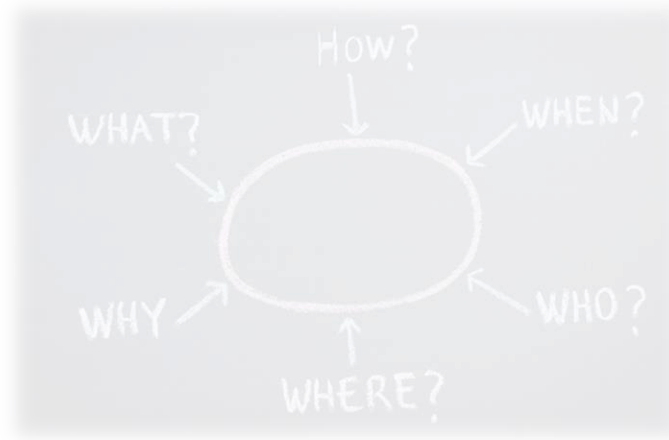
**Double-check
free text fields**

What are the next steps after a vaccine administration error?

Next Steps After a Vaccine Administration Error



**Notify patient
or the parent**



Assess how the
error occurred

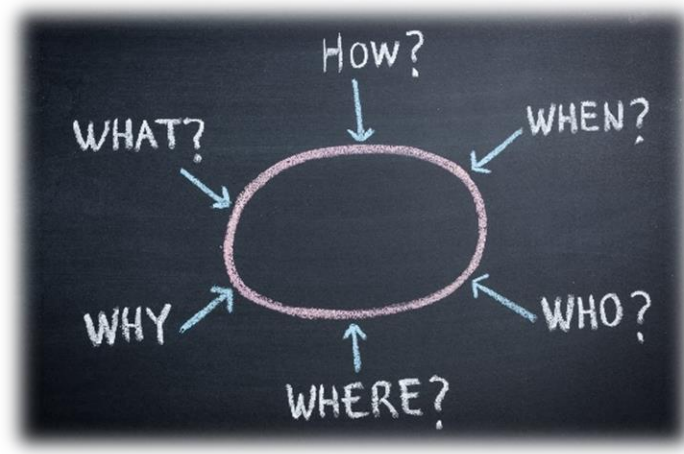


Implement strategies
to prevent errors

Next Steps After a Vaccine Administration Error



**Notify patient
or the parent**



**Assess how the
error occurred**

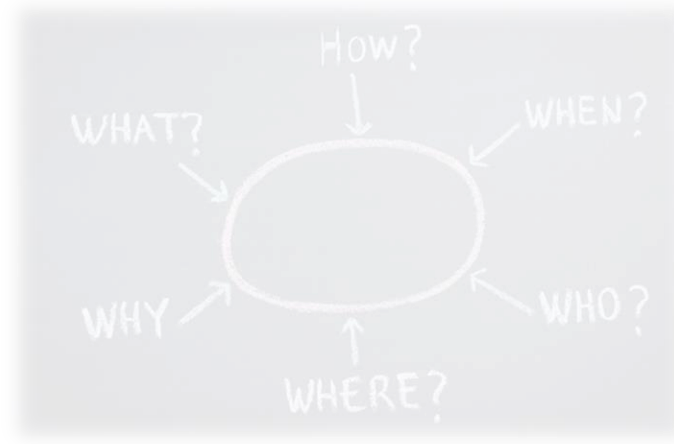


**Implement strategies
to prevent errors**

Next Steps After a Vaccine Administration Error



Notify patient
or the parent



Assess how the
error occurred



Implement strategies
to prevent errors

Reporting Vaccine Administration Errors

VAERS

Vaccine Adverse Event Reporting System

www.vaers.hhs.gov

Reporting Vaccine Administration Errors



For COVID-19 vaccines, providers are **required** to report:

- Any administration error (whether or not it was associated with an adverse event)
- Serious adverse events
- Multisystem inflammatory syndrome
- COVID-19 hospitalizations or deaths

Even if it is not clear that a vaccine caused the adverse event, these events should be reported

Do you repeat the dose if an error occurred?

COVID-19 Vaccine

Repeating a Vaccine Dose

- Incorrect site/route
- Incorrect age: Moderna younger than 18
- Supersize dose
- Subsize dose
- Temperature deviation
- Do NOT repeat the dose
- Do NOT repeat the dose: can give a second dose of Moderna, even if not yet 18 years
- Do NOT repeat the dose
- If more than or equal to $\frac{1}{2}$ the dose, do NOT repeat the dose, if less than $\frac{1}{2}$ the dose repeat the dose in opposite arm
- Contact manufacturer: if manufacturer says dose counts, do NOT repeat dose. If manufacturer says dose should be repeated, give ASAP

COVID-19 Vaccines:

[Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States](#)

COVID-19 Vaccine

Repeating a Vaccine Dose

- Expiration/BUD violation
- Coadministration: 14 day violation with another vaccine
- Coadministration: 90 day violation with COVID-19 passive product
- Minimum interval violation
- Dose given after 6 weeks
- Contact manufacturer: if manufacturer says dose counts, do NOT repeat dose. If manufacturer says dose should be repeated, give ASAP
- Do NOT repeat the dose: this is not considered an error
- Do NOT repeat the dose: this is not considered an error
- Do NOT repeat the dose
- Do NOT repeat the dose: this is not considered an error

COVID-19 Vaccine

Repeating a Vaccine Dose

- Mixed brand series
- Pfizer-COVID-19: Only diluent administered
- Pfizer-COVID-19: No diluent
- Pfizer-COVID-19: incorrect diluent
- Pfizer-COVID-19: incorrect diluent volume: too concentrated
- Pfizer-COVID-19: incorrect diluent volume: too dilute
- Do NOT repeat the dose
- Repeat the dose ASAP
- Do NOT repeat the dose
- Contact the manufacturer: if the manufacturer says the dose should be repeated, or is silent, repeat in the opposite arm.
- Do NOT repeat the dose
- If total volume greater than 4.0 mL after reconstitution: too dilute, need to repeat

Additional Resources

Additional Resources

COVID-19 Vaccines:

[COVID-19 Vaccines Authorized for Emergency Use](#)

[How to Enroll as a Healthcare Provider](#)

Resources for [Pfizer-BioNTech](#), [Moderna](#), and [Janssen](#) COVID-19 Vaccines

[FAQ for Optimizing COVID-19 Vaccine Preparation and Safety](#)

Routine Vaccines:

[CDC immunization schedules](#)

<https://www.cdc.gov/vaccines/ed/webinar-epv/index.html> (PINK BOOK WEBINAR SERIES)

Additional Resources

You Call the Shots:

[Preventing Vaccine Administration Errors](#)

[Vaccine Administration: Needle Gauge and Length](#)

You Call the Shots: The Educational Series

<https://www.cdc.gov/vaccines/ed/youcalltheshots.html>

Additional Resources

[*General Best Practice Guidelines for Immunization: Timing and Spacing of Immunobiologics*](#)

[Additional Resources for Healthcare Providers](#)

Acknowledgments

VTF Clinical Education Team

- Valerie Morelli
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- Mark Freedman
- Jared Hogg
- Bridget Hall
- Kristy Mugavero

CDC COVID-19 Response Team



Obtaining Continuing Education

- Continuing education is available for nurses, medical assistants, and pharmacists.
- Successful completion of this continuing education activity includes the following:
 - Attending the entire live webinar or watching the webinar recording
 - Completing the evaluation available after the webinar or webinar recording
 - **On the evaluation, please mark Yes if you're interested in CEs and please specify which type of CE you wish to obtain**
 - CE certificates will be automatically sent via email after evaluation completion
- Expiration date is 4/29/22
- If you have any questions about CEs, email Trang Kuss at trang.kuss@doh.wa.gov

Questions?

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